DAKOTA COUNTY DISLOCATED WORKER PROGRAM
PRIORITY OF SERVICE SCREENING TOOL

Please check which of the following best describes you:

❑ VETERAN

All veterans that have served at least one day of active duty with other than a dishonorable discharge.

❑ QUALIFIED VETERANS SPOUSE

- *Spouse of a Veteran who:*
  - *has a total disability resulting from a service-connected disability;*
  - *died of a service-connected disability;*
  - *died while a disability so evaluated was in existence.*
- *Spouse of an active duty member of the Armed Forces who has been listed as Missing in Action for more than 90 days or was captured in the line of duty by a hostile force or forcibly detained by a foreign government or power.*

❑ UNIVERSAL DISLOCATED WORKER

Within the past 3 years, you worked full-time (31+ hours per week) for at least 12 months.

❑ TRADE ADJUSTMENT ASSISTANCE (TAA)

You received notice of employment termination from a worksite certified for TAA (your employer likely would have informed you of this prior to your employment termination).
Name of employer: _____

If you are not any of the above, you do NOT meet the initial eligibility criteria and cannot apply for this program.

If you are a dislocated worker and are one of the above, check the appropriate box, complete and submit this form to the Resource Room staff. *Print clearly* – information will be distributed by email if an email address is provided below (check your spam folder).

NAME: _____ **PHONE NUMBER:** _____

ADDRESS: _____ **COUNTY:** _____

CITY/STATE/ZIP: _____ **CRS/MNW USERNAME:** _____

EMAIL ADDRESS: _____

LAST POSITION: _____ **COMPANY:** _____

DATES OF EMPLOYMENT : _____ **to:** _____ **SALARY:** _____

I authorize the Department of Employment and Economic Development and the county service providers to share information in order to determine priority of services for the Dislocated Worker program under Title I. I understand this authorization will expire one year from the date of signature on this form or at the completion of my participation in the program including follow-up time.

I confirm that the information provided above is accurate and true to the best of my knowledge (falsification may result in disqualification from the Dislocated Worker Program).

SIGNATURE _____ **DATE** _____